Addendum to SUMMARY AND RESPONSE TO PUBLIC COMMENTS July 16, 2010
California Department of Insurance
CCR Title 10, Chapter 5, Subchapter 2, Article 11

Verbatim Text of Comments	Response
Assoc. of Ca. Life & Health Ins. Co. (ACLHIC) dated 5/2/10	**Response to ACLHIC**
Section 2274.76 Agent Attestation and Notification Requirements When Health Insurance Applications Are Submitted to Insurers Again, consistent with the revisions made in Section 2274.74 (c), the standards of this section should not be applicable if an insurer decides not to rescind, cancel or limit a policy or certificate based on the health history or health status of the insured. Should an insurer not take one of these actions, the insurer would assume the underwriting risk for any advice an agent gave an applicant to complete an application. Therefore, there it would not be necessary to comply with the requirements of this section in that instance. ACLHIC recommends the addition of the following language as a new Subdivision (h): "However, in the event the insurer undertakes never to rescind, cancel or limit a policy or certificate based on the health history or health status of the insured, Subdivisions (a) – (g) of this Section 2274.76 impose no duty on the agent or insurer to comply with the agent attestation and notification requirements."	**§2274.76** The commenter asks the Department to waive the agent attestation required by CIC Section 10119.3 in the event that an insurer decides not to rescind, cancel or limit a policy or certificate based on the health history or health status of the insured. The language of CIC Section 10384 which is referenced in Section 2274.74 (c) and the revisions to the original text made in that section authorizes the revised language. However, Section 2274.76 concerning Agent Attestation requirements interprets and makes specific CIC Section 10119.3 not CIC 10384. The waiver of agent attestation suggested by the commenter is not permitted by section 10119.3 while a waiver of medical underwriting requirements is allowed under section 10384. The Department lacks authority to exempt agents from making the required attestation under CIC 10119.3 under the circumstances offered by the commenter, i.e. when an insurer declines to rescind, cancel or limit a policy or certificate. The Department lacks the authority to waive the insurer's obligation to obtain an agent's attestation when assistance to an applicant is provided as

	required by CIC Section 10119.3 and these regulations. As a result, the Department is not authorized to make the change suggested by ACHLIC to Section 2274.76. The Legislative intent behind these two statutes- CIC 10384 and CIC 10119.3- is entirely different and the comparison made by the commenter in not applicable.
Analysis Group – Attachment to ACHLIC letter dated 7/20/09	**Response to Analysis Group**
Summary of Analysis Group findings: Mr. Bruce Deal, Principal with the Analysis Group is an economist whose Group works with hospitals who comply with requests for medical records. Although he comments on the medical underwriting process at several points in his paper, he offers no underwriting or actuarial credentials to support those observations or findings. His findings are summarized below: • IF the proposed regulations are interpreted to require insurers to obtain medical records for every health insurance applications, Increased underwriting costs will be passed on to insureds in the form of higher premiums. • IF premiums are increased to cover the additional costs of obtaining medical records, individuals who cannot afford the higher premiums will forego purchasing individual health insurance. • Mr. Deal predicts that an additional 35,000 to 50, 000 Californians would drop their health insurance IF this regulation is interpreted to require medical records be obtained for every health insurance application, thus resulting in fewer individuals covered by individual health insurance in California.	The Department notes that Mr. Deal's conclusions are based on an assumption as he noted "*as I understand the proposed regulation, IF it is interpreted in certain ways, one of the effects is that health insurers could now be required to order ..medical records for virtually all applicants for individual health insurance".* He then proceeds to premise his entire analysis on the mistaken assumption that the proposed regulations do in fact require insurers to obtain medical records in all cases. However, this is not a valid or true assumption since the regulations do NOT establish this requirement for all applicants. To the contrary, the regulations require insurers to obtain at least a minimum of ONE outside source of health history information, which could be, but is not required to be,

Mr. Deal predicts that a requirement to obtain medical records for every health insurance application will also result in unacceptable delays in application decisions causing applicants avoidable stress while waiting for an insurer to decide whether or not to offer coverage.	medical records and then, only if available. Other sources of outside health history information are internal claims data, commercially available pharmaceutical information and a PHR. Accessing these data sources are required only if they are available. Section 2274.74(a) also limits the types and degree of underwriting activities, such as whether or not to obtain medical records, to match the requirements of the insurer's own medical underwriting guidelines. This requirement comports with today's industry standards and does not necessarily require an increased use of medical records for medical underwriting as a result of the regulations. An exception to this would be for an insurer who is currently not conducting sufficiently robust medical underwriting to comply with current statutes. In fact, a recent Department analysis, performed by outside actuaries, of the reasons provided by insurers to explain why recently filed rate increases are necessary make NO mention of the increased costs of medical underwriting. The actuarial analysis of the most recent major rate filing with the Department noted that the increase in medical trend (change in health care costs over time) was the major driver in health

	insurance rate increases; medical underwriting was not even mentioned. This particular insurer has already ramped up its medical underwriting as a result of a rescission-related settlement If indeed an increase in medical records occurred as a result of more robust underwriting and if those costs were to contribute significantly to premium increases, one would expect this cost contributor to be mentioned in the insurer's rate filing with the Department. In addition, Mr. Deal fails to mention that many contracts between an insurer and a medical provider (known as PPO contracts) require the Network provider to provide to the insurer AT NO CHARGE and within a very short time frame a copy of requested medical records for a patient. To the extent insurers have this provision in their PPO contracts, most doctors and medical groups in the State are required to provide, at no charge to the insurer, requested medical records within a few days.
Blue Shield Life & Health (BSL&H) 7/20/09	**Response to BSL&H**
Section 2274.74 - Regulation exceeds scope of applicable statute **A. *The proposed regulations must be amended to clarify that they do not impose underwriting obligations in the absence of efforts to rescind, cancel or limit a policy.*** As noted earlier, this regulation purports to regulate the underwriting	**BSL&H RE: §2274.74** **A. Agree.** The Department proceeded to add the following sentence to the end of subparagraph (c) to address this concern: "However, in the event the insurer

requirements set forth in Insurance Code Section 10384. Indeed, the heading of the regulation notes that it sets standards for "avoiding postclaims underwriting". Postclaims underwriting only occurs under Section 10384 if an insurer seeks to rescind, cancel or limit a policy due to the failure to have completed pre-issuance underwriting or to have resolved reasonable questions. Thus, if an insurer is not seeking to rescind, cancel or limit a contract, the statute does not impose any particular underwriting standard that must be followed before issuing the policy. In such cases, an insurer is not required to satisfy any particular underwriting obligations; indeed, it does not need to underwrite at all. The language needs to be clarified to make clear that this regulation is not seeking to impose underwriting requirements in the absence of efforts to rescind, cancel or limit a policy.	undertakes never to rescind, cancel or limit a policy or certificate based on the health history or health status of the insured, Subdivisions (a) and (b) of this Section 2274.74 impose no duty on the insurer to underwrite that policy or certificate." **B. Disagree.** The Department disagrees with the commenter's overly narrow constricted reading of the statute, CIC 10384.
B. *The proposed regulation improperly enlarges the underlying statute.* The regulations specify in subsection (c) that if an insurer fails to comply with the proposed underwriting requirements, it is: [p]rohibited from rescinding, canceling, limiting a policy or certificate, or increasing the rate charged, subsequent to receiving: (1) a request for authorization of service or verification of eligibility for benefits; (2) notice of a claim; (3) a claim or a request for a change in coverage, or (4) any other communication that puts the insurer on notice of a claim. There are several problems with this proposed regulation. 1. This regulation enlarges improperly the scope of Section 10384, which defines prohibited postclaims underwriting. That statute states that a rescission is prohibited if the rescission is "due to" (*i.e.*, the result of) the insurer's failure to complete underwriting and resolve any reasonable questions arising from the application. Thus, for a rescission to be prohibited under Section 10384, there must be both a failure	1. CIC 10384 imposes a broad, overarching duty on the insurer to complete medical underwriting AND resolve all reasonable questions arising on or from the application. On its face, it does not require that the specific reason or reasons for a rescission are ultimately attributable to a specific failure

of underwriting and a link between that failure and the rescission. Subsection (c) eliminates the statutory requirement that rescission is only prohibited to the extent it would be the result of the particular underwriting failure. Under subsection (c), a rescission is prohibited even if it was not "due to" the underwriting failure. For example, if an insured conceals in his application the existence of a particular significant medical issue and none of the underwriting procedures proposed by the regulation would have led to its discovery, the postclaims underwriting statute would not prohibit rescission based on that concealed condition. The CDI's proposed subsection (c) would prohibit rescission in that circumstance, and thus contravenes California law.	in the insurer's underwriting. CIC 10384 plainly requires that insurers complete medical underwriting regardless of the subsequent reason for the rescission. The primary goal of these regulations is to provide a specific description of the kinds of medical underwriting activities and the circumstances and parameters around that process which define when an insurer has accomplished the statutory duty. In response to the commenter's hypothetical, if the insurer can prove that it met the standards set forth in Section 2274.74 and that none of the underwriting activities reasonably undertaken would have detected an insured's concealed information, the insurer would not have engaged in prohibited postclaims underwriting. This fact pattern is presented in the Nieto v. Blue Shield case where the court found both that the applicant had concealed material information that went undetected during Blue Shield's pre-issuance underwriting AND the court found that Blue Shield has completed medical underwriting and therefore had conducted a legal rescission under CIC 10384. The regulations do not enlarge on the statute since they continue to require an insurer to fulfill the duty to complete medical underwriting yet prove that such underwriting

	would not have detected the applicant's omission or misrepresentation of a material fact.
2. Subsection (c) defines prohibited postclaims underwriting as the "rescinding, canceling, limiting ... or increasing the rate charged". This improperly enlarges the statute, which does not mention anything about prohibiting rate increases. Subsection (c) is also imprecise and confusing. While we do not believe this is the intent of the section, it could be construed as prohibiting any rate increase, even if applied to all insureds at any subsequent time, and this would exceed the scope of regulatory authority. In addition, as written, subsection (c) could be read to prohibit a rescission subsequent to a claim, even where the claim was paid already by the insurer.	**2. Disagree.** The statute references rescinding, cancelling or limiting a policy or certificate; increasing the rate charged is a specific type of limitation to the policy. The commenter is correct that it is not the Department's intent to abrogate or render inapplicable other provisions of the Insurance Code which govern how insurers can properly give notice to insureds of a rate increase and statutes which require filing those proposed rate increases with the Department. Subsection (c) cannot be read to prohibit a rescission subsequent to a claim in all cases if the entire sentence is read including the first part "Unless ***the insurer has fully complied with Subdivisions (a) and (b) of this Section 2274.74...".*** Of course, IF the insurer has fully complied with those subdivisions, the insurer is obviously free to rescind subsequent to receipt or notice of a claim, whether or not the claim is paid.
3. The CDI properly recognizes in its "Notice of Proposed Action" that if an insurer did not complete its underwriting, the proposed regulations will prohibit a subsequent rescission "unless it is shown that the applicant committed fraud when completing the application." Notice of Proposed	3. The harmonizing of the Insurance Code's prohibition of postclaims underwriting and the Civil Codes governing fraud in fact-specific rescission cases is left to the courts not

Action, at Page 5. As an equitable remedy, rescission may always be supported if the insured willfully misrepresented his or her health status or history in order to procure coverage. The Insurance Code and Civil Codes both support the fact that a person who engages in fraud cannot profit from their misconduct by keeping the coverage improperly procured. *See*, Ins. Code § 10380; Civil Code § 1692. Obviously, the Department is not intending by this proposed regulation to put itself in the position of condoning, encouraging or rewarding that type of willful misconduct. The proposed regulation, however, does not make it clear, as in the Department's Notice, that the proposed regulation does not apply in such cases. Subsection (c) appears to state that that a rescission is barred in all cases if the insurer did not complete medical underwriting, even when an insured set out to deceive the insurer. The proposed regulation must be clarified to make it consistent with the law.	these regulations. The Department lacks authority to ignore or waive the statutory prohibition of postclaims underwriting if fraud in the inducement of an insurance contract is present. In fact, the Nieto court recognized this fact and even upon a finding of fraud by the applicant, it went on to apply CIC 10384 and subsequently found that Blue Shield had proved that it had met its duty to complete medical underwriting and resolve all reasonable questions as required by CIC 10384. The regulation as written is consistent with Nieto; see discussion of the Nieto case in the Final Statement of Reasons.
C. ***The proposed regulation is confusing, and could be read to impose inflexible and excessive underwriting obligations that will harm consumers.*** Equally troubling, the various underwriting requirements imposed by Section 2274.74 are vague, and written in a manner that would result in large premium hikes and enormous delays in the ability to process applications in a timely manner due to their overly burdensome obligations. This will end up harming the very consumers that the CDI is seeking to protect. We discuss these issues below. 1. We do not believe that the general statement within Section 10384 that mentions the completion of medical underwriting provides the CDI with regulatory authority to dictate how the industry must conduct its medical underwriting by laying out broad, inflexible dictates that must be followed in all cases, regardless of need.	**C. Disagree** that Section 2274.74" lays out broad inflexible dictates that must be followed in all cases, regardless of need." The Department has revised text to clarify its original intent. As revised, Section 2274.74(a) constrains the type of medical underwriting activities in several ways: 1. Only requires one source of outside health history information and only if available, unless the insurer's own medical underwriting guidelines and the individual's application dictate more intensive information gathering and underwriting. 2. Sets the insurer's medical underwriting

2. This proposed regulation is inherently confusing because it includes numerous subparts that attempt to articulate underwriting requirements, but they do so in different ways and using different language. If this regulation is not deleted in its entirely, the Department should articulate the standard once, to eliminate confusion and internal inconsistencies.	guidelines and rating plan as the determinative document with respect to the number, type and degree of medical underwriting activities that should be undertaken in a specific case.
3. The requirements imposed under Section 2274.74 are confusing in other significant respects, and if interpreted literally would be excessive and inappropriate. For example, various provisions contained within proposed Section 2274.74, if read literally, could be viewed as requiring insurers to obtain and evaluate all of the following items, for every application, regardless of need: the applicant's prior claims data, pharmaceutical information, PHR data and prior medical records. For example, subsection (a)(3) states that the underwriting process must include reviewing and evaluating each applicant's health history using "reasonably available sources of health history information for each individual applicant, including but not limited to the applicant's medical records ...". Similarly, subsection (a)(4) generally requires "checking reasonably available health history information". It is entirely unclear what this entails. In particular, It is unclear whether the CDI is seeking to require that insurers must use all of those particular underwriting tools, including ordering the applicant's complete medical records when evaluating every application; or whether the proposed regulations are aimed at requiring insurers to have reasonable cross-checks on an applicant's self-reported information, which can include, when reasonable and appropriate, tools such as the various ones listed in the proposed regulation. Insurers can reasonably and efficiently cross-check applications using a variety of underwriting tools tailored to the specifics of a particular application. These can include recorded telephone interviews, checking the insurer's internal databases or use of commercially available databases. Of course, in certain cases, it will be prudent to order medical records to evaluate an application. But in many situations, other underwriting tools may be more than sufficient to fully evaluate and cross-check an	3. Disagree that the proposed text requires insurers to undertake every single listed medical underwriting activity even if not needed. However the revised text sets parameters on when and which activities are to be undertaken in the last two sentences of Subdivision (a). Note that the limitations on when and which medical underwriting activities are expected are driven largely by the insurer's own medical underwriting guidelines. Medical underwriting, by definition, requires judgment to be exercised, hence the use of words like "as reasonable and necessary". These judgments are expected to be made by an insurer's underwriters in the course of underwriting a particular application. The regulations do not call for ordering medical records in every single case, even prior to the revisions to Subdivision (a). Agree with the commenter that insurers can and should reasonably and efficiently cross-check applications using a variety of underwriting tools such as the ones listed by

application. Insurers must have the flexibility to utilize a broad range of underwriting tools available to them to fit the particular situation presented by an application. It would be highly improper for the CDI to mandate that any one particular tool — or all of them — must be used in every single case. Of course, if an insurer does not use proper means to underwrite generally or in a particular case, the availability of judicial review in a rescission case, or future Departmental audits, can operate as a check. If the Department is not intending to mandate that insurers must now order complete medical records for every application, it should clarify the proposed regulation so that there is no confusion on that point. We note that the CDI's Initial Statement of Reasons does not appear to include any requirement to order medical records in every case. For example, subsection (a)(3) could be revised to state: "(3) Reviewing and evaluating each individual applicant's health status and health history using information self-reported by the applicant in that individual's application, along with other sources as may be necessary and appropriate in a particular situation to cross-check the application. Those additional sources can include, as appropriate in a particular case, review of the applicant's medical records, claims history with the insurer, PHR data (if available), or information contained in commercially available third-party databases."	the commenter. Section 2274.74 (a) as revised clearly allows insurers this flexibility in choosing and applying the tools based on the specifics of each application. CDI is not mandating any particular tool; it is only requiring that at least one outside, non self reported source of health history information be sought, and only if available. This standard is already widely established by most CA insurers in that the use of commercially available pharmaceutical databases are routinely used as are checking an insurer's own internal claims database. The commenter's suggested revisions have been largely included in the CDI's revision to Section 2274.74 (a) in the amended text.
If Section 2274.74 is viewed as requiring insurers to order and review the complete medical history of every person applying for coverage in every case, any such rigid and inflexible obligation would impose an enormous and unprecedented undertaking that would result in huge premium hikes and enrollment delays. It is not hyperbole to state that such a requirement could jeopardize the individual market as we know it. At a minimum, it would lead to tens of thousands of consumers having to drop their coverage based on the huge costs associated with any such shift in the required underwriting. Consistent with its practices, Blue Shield Life strongly supports the fact that	As noted above, CDI never intended to require insurers in every case to order medical records. This is a misreading of the original text. As such, the commenter's prediction of huge premium hikes and enrollment delays are not tenable. It's possible that more complex or incomplete health insurance applications will require more underwriting than previously being

insurers should have reasonable procedures to minimize the risk that applicant errors or omissions will go undetected. The key question, we believe, is what level of checks is reasonable? We believe that, to the extent that the proposed regulations are aimed at requiring insurers to order medical records on every applicant, they would not be reasonable and would not strike an appropriate balance between the prudent need to check the accuracy of application data and the need to keep premiums reasonable and to process thousands of applications in a timely fashion. The average cost of ordering a particular medical record is approximately $50, and it can take up to thirty days or more to obtain a medical record from a provider. Assuming the average person has seen three to five providers over 10-year period (a conservative estimate), the cost of ordering anywhere from fifteen to twenty separate medical records for a typical application for a family of four would be significant. Those costs would be passed though to consumers in the form of higher premiums. Further, many applicants apply to several insurers at the same time. Under the proposed regulation, if it is interpreted to require the ordering of medical records, each of those insurers would be ordering the same records from the same providers for the same applicants. Obviously, any such requirement would exponentially increase the burdens on providers to respond to all of these inquiries from insurers. In addition to the immense burdens on providers, the increased volume of inquiries will impact the time it would now take those providers to send the medical records to the insurers. If the records currently take upwards of thirty days to arrive, that time lag will increase significantly under the new proposed regulation. Moreover, medical records will frequently refer to additional medical professionals who the applicant has seen. If the insurers must then seek those records as well in a second series of requests — adding another thirty days or more to the underwriting process. It is not difficult to imagine the enormous delays in processing applications that would result by an inflexible obligation to order complete records for every application when other effective underwriting tools are available. The consequences would be dire to the market. The individual market is highly cost and time sensitive. It is largely made up of individuals	conducted, but these are precisely the types of applications where more rigorous underwriting should be undertaken. As noted, CDI never intended to require that medical records be ordered in every case therefore the *additional* costs noted by the commenter should not be incurred as part of compliant underwriting. Additional costs would be incurred by insurers who are not currently conducting the robust and rigorous underwriting required by the postclaims underwriting statute. Disagree that there will be dire consequences in the market when insurers undertake to comply with the underwriting regulations. In fact, as a result of settlements

who do not have access to government-funded or subsidized programs or group health plans provided primarily through their employers. Those individuals must either purchase insurance on their own or face the economic and health risks associated with not having health coverage. Health plans and insurance companies play a critical role by attempting to make individual health coverage available to the largest number of people at the most affordable rates. In 2004, for example, approximately 6.5 million Californians were uninsured, with the majority working for companies that do not offer health benefits to their employees through sponsored group insurance.1 These people, along with self-employed workers, early retirees, and the unemployed are the groups that most frequently purchase individual health coverage. The logistical and cost issues discussed above are critical to the individual health care market for various reasons. Because this market is made up of persons who do not have the options of group or government coverage, the individual market is highly price-sensitive. A 2005 RAND Corporation study showed that even a modest rate increase would cause about 16,000 individuals per quarter to drop their coverage because it would be too expensive.2 These are not hypothetical numbers: the Department must understand and appreciate that added costs and delays will cause many thousands individuals to drop into the ranks of the uninsured. There is a real price that will be paid by Californians if the Department mandates "over-underwriting" through inflexible requirements. Many consumers will not be able to afford coverage. Many more are not in a position to wait 30 to 60 days — or longer — while their prospective insurer is forced to locate all their previous providers, order all of their medical records and then review their entire medical history. The probable consequences of the regulations, both in terms of the cost and delay, are contrary to common sense and sound public policy. The immense burdens required by the requirements effectively could cause insurers simply to abandon rescission altogether rather than saddle insureds with the increased premiums and delays. Should that occur, there would be	entered into by the state's largest health insurers and HMO plans, much more rigorous medical underwriting has already been agreed to as part of these insurer's corrective action plans. So noted. The Department disagrees that cost increases due to medical underwriting will cause individuals to drop coverage; it's much more likely that rate increases by insurers to maintain margins and to cover increased marketing and advertising costs will cause rates to increase, not medical underwriting costs. The Department disagrees with this insurer's prediction that applicants will be encouraged to submit false applications as there is no evidence that insurers are giving up their right to medically underwriting health insurance applications, even with the advent of tighter constraints on rescissions imposed by recent federal health care reform laws that become effective soon.

no effective deterrent to the submission of false application information or adverse selection. The experience in other states that have experimented with effectively eliminating rescission rights (*i.e.*, guaranteed issue coverage) with corresponding no mandate for all persons to buy insurance coverage has been disastrous. In Washington state, for example, premiums sky-rocketed because many consumers understandably held off on buying insurance until they needed care and then cancelled coverage once the care had been rendered or after utilizing far more in medical care than they had paid in premiums for that limited time period. The new proposed underwriting burdens threaten the same result in California, which does not have a mandate for all residents to buy health insurance. Finally, the proposed underwriting requirements fail to address or recognize the fact that certain products such as short-term health policies reasonably require a different degree of underwriting, and that insurers should have the ability to reasonably rely on applicants to properly answer the few short and basic questions about their health included on an application for a short-term policy. These types of products are designed for persons who need immediate, short-term coverage to fill a temporary gap. The time that it would take to underwrite an application under the underwriting obligations contemplated by the proposed regulation would defeat the very purpose of the short-term product for the consumer who needs it. 1 RAND Corp. Individual Health Insurance Market Snapshot, California HealthCare Foundation, 2005 ("RAND Study"), p. 2, *available at http://www.chcf.org/documents/insurance/SnapshotIndividualMarket05.pdf* 2 RAND Study, p. 18	The Department has no information on Washington state's experience with guaranteed issue and declines to comment. It is very clear that these regulations do NOT require guaranteed issue of insurance for individual applicants. The Department notes that CA insurers have been subject to guaranteed issue for small employer (2-50 persons) groups for many years and in spite of " the sky will fall" predictions made by insurers in advance of that legislation, the small employer market has done quite well and insurers have been able to maintain this as a profitable market sector. The statute does not authorize the Department to exempt or waive the statute requiring completion of medical underwriting for any subset of individual health insurance products as requested by the commenter.
Blue Shield Life (BS) 15-Day Comment letter dated 5/4/10	**Response to BS**
Preliminarily, Blue Shield Life notes that the revised text reflects a response to only a few of the detailed comments submitted on July 20, 2009 in response to the original proposed regulations by Blue Shield Life and by the Association of California Life & Health Insurance Companies ("ACLHIC").	The Department notes that the revised text issued after the required 15 day notice amends the original text to reflect the Commissioner's desired changes. Many of

With minimal exceptions, the revised text does not cure or even address the numerous legal issues identified in the prior comments. Blue Shield Life urges the Commissioner to reconsider those comments and to correct those provisions that exceed the Department's authority pursuant to California law as specifically addressed in those letters.	the changes to the original text were made in direct response to comments submitted, including those submitted by Blue Shield and ACHLIC. For example, the sentence added to Section 2274.72(d) definition of "Personal Health Record" was made in direct response to ACHLIC comments. Both Blue Shield and ACHLIC complained that the original text, in their view, would have required an insurer's reliance on internet- based consumer maintained health records. This was never the intent of the Department. In response, the definition of a Personal Health Records, for purposes of these regulations, was further clarified by expanding the definition of "Personal Health Records" as found in Section 2274.72(d). Please see responses regarding comments made in original letters regarding Department's authority. Another change to the original text that was made in direct response to comments including those from Blue Shield and ACHLIC is found in Section 2274.74(a). The last two sentences of this subparagraph was added to further clarify that, at a minimum, only one source of health history information from an outside source must be attempted to be obtained in order to complete medical underwriting. The last newly added sentence

	to this subparagraph further clarified that an insurer must engage in the listed medical underwriting activities only to the degree necessary to assure that the detailed health history information required by the insurer's own medical underwriting had been obtained prior to issuance of the policy. This text circumscribes the degree of medical underwriting required in order to avoid prohibited postclaims underwriting as requested by commenters. Further, a very significant change to the original text that was made in direct response to comments, including those offered by Blue Shield and ACHLIC, is found in the last sentence of Section 2274.74(c). Addition of that sentence clarifies that IF an insurer undertakes never to rescind, cancel or limit an in-force health insurance policy, the standards for medical underwriting designed to avoid prohibited postclaims underwriting do not apply to that insurer for that policy. As a result, the revised text reflects changes made to the most important detailed comments submitted on July 20, 2009 by Blue Shield Life and by the ACHLIC in addition to other comments.
Council for Affordable Health Ins. (CAHI) J. Wieske 07/18/09	**Response to CAHI**
Section 2274.72 Definitions We are concerned with the inclusion of a definition for a "Personal Health	**CAHI §2274.72** These regulations place the decision to

Record" ("PHR"). In the future, this new term may be used differently in different states complicating its use in California. As we understand it, the information included in the personal health record is primarily the insurance company's claims information. While this information is potentially useful from an underwriting standpoint (in fact depersonalized claims information is often used in large group underwriting), we are concerned that HIPAA privacy rules, and other state privacy rules will make this information difficult to transfer.	share a PHR with the applicant. It is fully within an applicant's right under HIPAA to make their PHR available to insurer as part of the insurer's consideration of the health insurance application. Agree with the commenter that the benefit of a PHR is that its source information is claims information which is potentially useful from an underwriting standpoint.
Section 2274.73 Standards for Health History Questions on an Application for Health Insurance Coverage We have several specific concerns in this section. Subsection 2274.73 (a) states in part "a PHR shall be requested and, if available, relied upon during medical underwriting in addition to or, if sufficient, instead of health history questionnaires." At this time, we are not sure whether insurers will provide a complete PHR, how individuals will request a PHR from their insurance company or insurance companies, how far back the PHR will provide medical information, or any details of the actual PHR. Currently, a PHR is an insufficient tool to conduct a formal underwriting review, and it should not on its own be "relied upon" or considered "sufficient" to conduct underwriting.	**CAHI §2274.73** See amended text at Section 2274.73(a) which addresses this comment. This change in the text makes use of the PHR one option available to insurers in addition to self-reported information.
Subsection 2274.73 (d) (4) states that insurers should: (4) Provide each applicant with the opportunity to indicate whether he or she is unsure of the answer, does not know how to respond to any individual health history question, or does not understand the question. Health history questions that offer response choices in addition to YES or NO, such as Not Sure, on a health history questionnaire may, as appropriate, satisfy this requirement. We are concerned that providing "Not Sure" as an option will actually lead to	**CAHI §2274.73(d)(4)** The purpose of requiring the response choice of "Not Sure" in addition to Yes or No is precisely to permit the applicant a full opportunity to answer accurately and truthfully. The Department agrees that applicants have an obligation to complete their insurance application to the best of their ability and to give complete responses. By requiring the Not Sure response option, the applicant will better be able to meet this obligation and the insurer will gain additional insight into the health history areas where further underwriting might be warranted.

more problems. Potentially, it allows individuals to game the system by proving vague answers – the very problem causing many rescissions today. Most applications have space for applicants to explain any yes answers further, and this would be more appropriate than providing a "not sure" answer. Subsection 2274.73 (d) (5) is also problematic. It states the following: (5) Offer the applicant an opportunity to indicate the applicant's inability to recall or remember the information requested. To the extent that such response choices impede the insurer's ability to apply its medical underwriting guidelines, the insurer shall pursue alternative methods of obtaining such information, including but not limited to telephone interviews, medical records or other sources of information. I am not sure how it is possible to underwrite a policy in which the individual is able to claim no knowledge of their own medical history. This inability becomes a blanket defense for the individual to claim they did not "intentionally" mislead the insurer, when in fact that is the very intent. Secondly, other information gathering techniques can be effective, and many carriers use those alternatives, but they can not be relied upon legally in the same way as a statement on an application. The unfortunate result is that by allowing vague answers and relying exclusively on oral communications like telephone calls, California will be encouraging fraud AND likely increasing the number of rescission investigations. Lastly, we are also concerned that the application itself will become unwieldy with all of the proposed changes. <u>*Section 2274.74 Standards for Avoiding Prohibited Postclaims Underwriting*</u> This section is completely unworkable. We agree that the overall goal should be to eliminate most rescissions, and that most information should be gathered prior to issuing the policy – especially when the applications yields some questions. But time and expense are important factors, especially in	The Department has had recent experience with the Not Sure response option and learned that insurers can in fact use this option to more efficiently underwrite an application. The statute requires questions to be clear and unambiguous. Response options are part of the question. In order to make the question clear and unambiguous, a Not Sure response option must be provided. If the applicant truly cannot answer Yes or No and the truthful answer is Not Sure, the applicant is unable to accurately respond unless the Not Sure response option is available. **CAHI §2274.73(d)(5)** Subsection 2274.73(d) recognizes the reality that many applicants will have difficulty recalling or remembering the health history information being requested. CDI believes it's best for insurers to be informed in these circumstances so the insurer can seek additional information, if necessary, from other more objective sources. Insurers also utilize structured recorded phone interviews conducted by trained personnel to question the applicant when they don't recall or remember required information. CDI has already approved an application for one insurer that meets the requirements of these regulations thereby confirming that it is not unwieldy.

the individual market. It appears to us that this section will require insurers to collect medical records for every applicant. In order to meet time frames applicants need and expect, every individual applying for insurance will need to visit all their doctors (and any hospitals) and collect all the medical records and pay for copies. The vast majority of applicants for coverage provide honest answers on the application. To go to heroic steps to find the individual that has deliberately misrepresented their medical history, will be very expensive. Medical records are more appropriately utilized when an individual is unclear about their medical history, or they have a medical condition which, depending upon severity might be insurable. This will be a very expensive process for some – and made worse for individuals who will need to be rejected for coverage to meet eligibility for the state's high risk pool. The alternative, insurance companies collecting the records, will result in underwriting grinding to a halt as we wait for doctors and hospitals to respond to our requests. We are also concerned that HIPAA privacy may also limit our ability to collect information from other sources including data collected by the company itself. Unlawful disclosures create stiff penalties for insurers, and possibly employees involved with those disclosures. The unfortunate net impact will be to increase the administrative difficulties for individuals purchasing health insurance. The time and cost required to meet this zero rescission goal will lead directly to an increase in the number of uninsured – clearly not the goal of this issue. While it can not be done by regulation, a rescission external review process could look directly to the issue of whether or not companies should have investigated the information prior to policy issuance. Short of that requirement, insurers should only be obligated to investigate any information	**CAHI §2274.74** Disagree. This section does not require an insurer to gather medical records for every applicant. To clarify, see amended text of Section 2274.74(a) which states that at least one source of objective health history information other than self-reported information is required. Use of additional sources is determined by the insurer and will depend on the health insurance application to be underwritten. Agree that medical records are useful if the applicant is unclear about their medical history. These regulations allow precisely such use by an insurer allowing the insurer to determine if and when medical records are needed to obtain the detail the insurer requires to meet the terms of its own medical underwriting guidelines. Applicants are required by health insurers to agree to allow the insurer to access the applicant's protected health information (PHI) under HIPAA. Such authorization is well within HIPAA and is routinely obtained. There is no evidence that more robust pre-issuance underwriting will lead to increased costs to insurers. Insurers can make more efficient use of outside sources of information. Insurers will be using easier to

disclosed on the application, and questions that have arisen as a result of any other collection information including telephone interviews. *Section 2274.78 Post-Contract Issuance Rescission or Cancellation Investigations* We are concerned with several issues in this section. First, some of the time frames are a little too ambitious for most insurers to consistently meet. For example, many insurers require multiple levels of review prior to a rescission (which may include a medical review, and underwriting review, and a review by management) before rescinding coverage. We're not sure seven days is enough time for all of these layers of review, and further we believe these more comprehensive reviews are to the advantage of the insured person. We believe the time frame should be extended to 10 business days. We are also concerned with sending information that the insurance company does not own – for example medical records – to the insured person. While referring to the medical records of a particular provider is appropriate, we're not sure the insurer has the right to forward the provider's records.	understand health history questionnaires which should yield more reliable self-reported information. Agree that the CDI lacks authority to impose an external review process on insurers at this time. **CAHI §2274.78** Disagree. The cost of undertaking extensive postclaims rescission investigations will be reduced. The cost of adjusting claims multiple times in the case of executed rescissions will be reduced. Administrative and legal costs associated with rescissions will be reduced. Underwriting will be more efficient as a result of the need to conduct more robust pre-issuance underwriting. Disagree. CDI believes the timeframes are fair to insurers and fair to consumers whose health insurance coverage is at risk. A timely resolution of a rescission investigation is in the best interest of both parties to the insurance contract as well as health care providers. Insured persons currently have a right to request their own medical records. The HIPAA authorization that insurers routinely obtain from applicants gives the insurer the right to share any and all health history information, including medical records, with

	the applicant/ insured.
Comments from Public Hearing-Oral Testimony	**Response to Oral Comments**
Mr. William Shernoff, Attorney Summary of comments - Represents victims of rescissions in legal actions. - Supports regulations as proposed. - Especially likes the standards for the health insurance application. - Applications are root of rescission problem; they are confusing, complicated and unintelligible. People can't remember every doctor they have seen in the last 10 years. - 1153 questions on questionnaire for husband and another 1153 for wife. - Especially objects to compound questions and supports that these types of questions are disallowed under the regulations. - Likes the "not sure" answer option. - Likes the requirement to use "lay" terms when possible. - Not one application out there today that complies with these standards. - Advises CDI to consider whether it can make sure that applications will meet these standards prior to CDI approval. - Supports standards for avoiding postclaims underwriting and projects that rescissions will dwindle if enforced. - Expects that standards will require carriers to spend more time and do due diligence upfront before issuing coverage and thinks this is good. - Big social problem when companies wait until someone falls ill to determine if they are eligible for insurance. - Rescission is a big profit center for companies who are making millions from it. - Likes that companies can only rescind under the Thompson test. - Supports the regulations and CDI's effort to make the process more	**Response to Mr. Shernoff** CDI accepts Mr. Shernoff's support for the regulations and will take under advisement the Department's job of authorizing health insurance applications that meet the standards set out in the regulations for future submissions.

fair.	
Anne Eowan, VP, Assoc. of Ca. Life & Health Ins. Co. (ACLHIC) Summary of comments: -Will provide written comments today. -Shares CDI's desire to establish uniformly administered application process and to put more transparency into the process. -Objects to the application of the regulations to the group market; recommends that they be limited to the individual market because that's where the problems have been. -Wants greater balance. Notes that 99.9% individuals never get rescinded. Actually less than one tenth of 1%. Pendulum swinging too far in the other direction with these regulations. -Concerned that regulations will require obtaining medical records in all cases and that this will add to cost of processing and delay in making an offer of coverage. Costs are burdensome. -Concerned that regulations be objective as possible and to avoid subjective requirements which will contribute to current ambiguity and litigation. -Concerned that prohibiting compound questions will make applications too lengthy, more than 100 pages. - Predicts that if insurers cannot meet the standards set for underwriting they will simply deny coverage. - Objects to regulation that favors and encourages use of Personal Health Record (PHR) because they are maintained by the individual and are not subject to attestation and are not a reliable source of medical information. Wants PHRS to be an optional source of health history. - Recommends a six month delay after regulations are effective to allow time for carriers to comply. -Timelines are too restrictive for conducting the rescissions. Delays in obtaining medical records could cause carriers to miss timelines. - Concerned about lack of market parity if CDI adopts regulations and DMHC has not even proposed. Half of the individual market is currently regulated by	**Response to Anne Eowan** The Department applied the regulations to health insurance policies that are medically underwritten, regardless of whether the coverage issued is "group" or "individual". This is in recognition of the fact that some group coverage does involve individual underwriting. The postclaims underwriting prohibition in CIC 10384 applies to all medically underwritten policies regardless of the type of policy. The Department lacks authority to carve out certain types of insurance products from the requirement to complete medical underwriting. If a type of coverage results from a medical underwriting process, it is subject to the statute. The Department has revised the regulations to further clarify that medical records are not required for every health insurance application; instead this decision is driven largely by the insurer's own medical underwriting guidelines. The regulations are written in as objective manner as possible given the nature of the subject matter. The Department retained the prohibition on compound questions because they are confusing, responses are unreliable and not helpful for underwriting.

DMHC through health plans. They will not be subject to CDI regulations. - Lengthy and intrusive application process caused by regulations will cause delay. -Claims that Department is proposing a 3rd party review when Dept is 3rd party. Wants regulations to allow carriers to use independent 3rd party reviewers instead of Department review. - Wants insureds to be required to file first appeal after rescission with carrier before accessing Department review. - Concerned that carriers might not know when underwriting is completed under the regulations.	The Department revised the definition of Personal Health Records to address this commenter's concern. Since so many carriers were required to change their health insurance applications as a result of enforcement action settlements, the Department determined that a six month delay in implementation of the regulations was not necessary. The Department reviewed the timelines for conducting a rescission in the regulations and given the carrier's ability to delay for good cause, retained the original timelines. The Department has no control over the rulemaking priorities of the Dept of Managed Health Care. Each Department has its own separate authority and must assume responsibility for pursing regulations as it deems necessary. The Department is confident that industry will devise and deploy new underwriting technology to speed up the underwriting process as has been happening already in the last 10 years. The Department lacks authority to require a consumer to access a carrier's internal appeals process before asking the Department to investigate. The Department is statutorily obligated to receive and investigate complaints for insurance consumers, regardless of whether or not the consumer has tried to file an appeal with the

	company first. The Department lacks authority to allow a carrier to substitute its proprietary independent review process for the Department's own consumer complaint services which must be made available to all insurance consumers in California.
Tyler Robison and Mark Robison Summary of the comments from Tyler Robison and Mark Robison: -Mark Robison is Tyler's Father. Tyler is 14 year old son. Tyler was victim of rapacious, unconscionable rescission by Blue Cross. -Mark has Masters in literature and language and has taught at University level; has good understanding of the English language. - Family had Blue Cross coverage for over 10 years. - Mark suffered a very serious auto accident in 1999 and was out of work recovering for over 1.5 years. Could no longer pay for health insurance coverage. - Coverage lapsed for 9 months before the family applied for individual coverage. - When Tyler was a year old he had a hernia operation during which doctor discovered undescended left testicle. Family advised at that time that if it doesn't descend on its own by age 8-9, surgery will be recommended. -Mother completed health insurance application for Tyler. - Blue Cross rescinded Tyler's coverage in August 2005 after he had the surgery for the undescended testicle in 2004. The family's coverage started in 2002. - Blue Cross rescinded based on the family's answer for the children to the question: "Does anyone have any sexual reproductive problems?" alleging fraud. We didn't think that this applied to our 4 year old and 9 year old children.	**Response to Tyler Robison and Mark Robison** The Department expressed concern and empathy for Mr. Robison's experience. The Department acknowledges Mr. Robison's support of the regulations. The Department lacks authority under any statute in the Insurance Code to require insurers to institute an independent 3rd party review requirement prior to rescission.

-Tyler's response to this question was the basis for Blue Cross rescission. -All health care services related to the surgery were prior authorized and approved by Blue Cross. -Blue Cross clawed back money it had paid to the hospitals and doctors and the bill collectors started to hound us. - My credit score was in the high 700's and now is in the low 4's. - The instability and pain caused by the rescission has taken a terrible toll on my family and I have suffered a divorce. We have been devastated and demeaned. Our family fell apart under the weight of the rescission and its consequences, including financial and emotional. -I support the regulations. - I want the Commissioner to institute 3rd party review of rescissions. Summary of Comments by Tyler Robison: - His view of the impact of the rescission and his operation by Blue Cross is different from his father's. - He remembers when his family was together and enjoyed time and vacation together. Now the family is apart and no one wants to be together. - This has been devastating for him and he feels he has lost the family togetherness.	No response required.
Armand Feliciano & Dr. Curran, California Medical Association Summary of comments from Armand Feliciano, representing the California Medical Association: -CMA has sponsored legislation for the past two years to address the problem of rescission. -Commend DOI and the Commissioner for proposing these regulations. -Overall supportive with a few suggestions. Also provided in writing. -CMA would like an "intentional" standard (of proof) to be required for insurers but understands that the CDI may lack authority. -Clarify that the Department recognizes a "knowing "standard in the	**Response to Armand Feliciano & Dr. Curran** The Department acknowledges the CMA and Dr. Curran's support for the proposed regulations. The Department lacks statutory authority or case law authority to impose an "intentional" standard of proof on insurers who pursue rescission of a health insurance contract

regulations. - Clarify that under a knowing standard it is insufficient to simply compare information in a medical records with information in a health insurance application. More is needed. -CDI should approve all health insurance applications. -Doesn't want cost of providing medical records to insurers passed on to doctors. -Add a requirement that the notice of rescission contain a few statements including that the individual should consider contacting an attorney and that the individual retains health insurance coverage during the rescission investigation. - If CDI has statutory authority to require independent 3rd party review, do it. Summary of comments from Dr. Curran of the CMA: - Dr. Curran is a practicing cardiologist in SF. - Notes that the housing, credit and health care crisis all have one thing in common: a fundamental loss of trust. - Consumers should be first over Wall Street. - Patients should be first. - San Francisco physicians support the proposed regulations.	alleging that the applicant misrepresented or omitted material information that they knew of. The Department originally included the "knowing"standard in the regulations but later revised the text in recognition of the federal health care reform law which imposes a higher "intentional misrepresentation of material information or fraud" standard on insurers who pursue rescission. The Department declined to affirmatively state the factual evidence required to prove the intent standard leaving this to the courts to determine. CDI does currently approve all health insurance applications that are part of the policy form. CDI has no authority over who pays for the cost of obtaining medical records obtained or requested as part of medical underwriting. CDI generally does not advise consumers whether or not they should seek legal advice at their own expense. The regulations include a provision stating that the insurer is required to pay claims during the rescission investigation and as long as the policy remains in force.
Jerry Flanagan, Consumer Watchdog Summary of the comments: -Consumer Watchdog has been tracking rescission issues and noted a spike in complaints in 2005. - Consumers buy insurance to rely on it when it's needed; they deserve to	**Response to Jerry Flanagan** The Department believes that the regulations implement and make specific the statutes cited and provide a balance between

rely on it. -Decries "wait and see" approach that insurers take to rescission and underwriting once claims start coming in. -Points out that Mr. Robison's innocent mistake should not have allowed rescission as he had no intent to defraud the company. -If this system is allowed to continue, insurance is worthless because it can't be relied on. -Keep in mind that it is the job of the insurer to assess prospective risk when they complain about how much more it will cost to underwrite health insurance applications. -Regulations should reflect the consumer's ability to rely on coverage. -Recent hearings on mergers in the health insurance industry revealed millions of dollars in bonuses paid to CEOs and others; in addition to upstreaming of very large dividends. DMHC recently criticized Blue Cross for upstreaming one billion in dividends to Anthem/ Well point. -Blue Cross has a 50% profit margin in the individual market. Consider this as you hear complaints about the increased cost of medical underwriting. -Clarify regulations to protect consumers. -Add the Thompson test to the Standards section. -Blue Cross' failure to look at its own records in the Robison case meant that they should not have been allowed to rescind since they didn't do their underwriting up front. - Recommends that CDI support AB 2. -Endorses layperson standard for underwriting. -Application clarity is important but not sufficient. - Need to add equitable remedy into regulations for wrongful rescissions; specifically a remedy which returns both parties to status quo ante. Missing from regulations. - Wants individual to be able to participate in post-contract rescission investigation if they want to. -Wants individual to be able to seek assistance from CDI before the rescission is executed.	consumer protection and the practical operations of a health insurance company. The Department did not add the Thompson standard to the Standards section (presumably Section 2274.74 because the question of the applicant's intent when completing the application does not arise during medical underwriting; it arises after the fact when rescission is at issue. This is the reason why the Thompson intent standard of "knowing and appreciating the significance of the information requested" was initially placed in the section on post-issuance rescission investigations. Since the enactment of federal health care reform, the Thompson standard will no longer apply as it has been replaced by the federal intent standard. The recommendation regarding AB 2 does not relate to the adoption of the regulations. The insurers are required to interpret responses on a health insurance application using a reasonable layperson standard. The Department lacks the authority to impose the requested equitable remedy. This remedy is only available through a civil action. The Department is statutorily required to provide assistance to insurance consumers

-Believes that these regulations are a substantial step towards protecting patients. -Asks that Commissioner contact Governor and ask him to get DMHC re-engaged in rulemaking on rescission. -Notes that national debate on health care reform underway and rescission is part of that but implementation, if it passes, will be a ways away. -Language on the "Not Sure" response option too loose; needs tightening. -Up to the patient whether or not to be involved in the rescission investigation. Patients should have an opportunity to explain as simply as possible whether or not they knew or understood the question that is the cause of the rescission. - Reasonable layperson standard should apply to the questions on the application and the post-contract investigation. - Believes that the percentage of individuals who actually misrepresent information is very small. - Make applications be clear. - Wants Department's "grievance" Department role to step in before rescission occurs.	whenever requested. As such, it is currently possible for an insured to request assistance from CDI as soon as they are notified of the commencement of a rescission investigation. The language on "not sure" response option in Section 2274.73(d) (4) has been clarified in response to this comment. The reasonable layperson standard does apply to both the questions on the application and during the post-contract rescission investigation since the questionnaire is typically the subject of the post-contract rescission investigation. The CDI will have greater ability to make sure that insurer's health insurance applications are clear once these regulations are adopted. The Department's complaint investigation services are available to consumers at all times as required by statute.